AMERICAN MEDICAL TIMES

Being a Weekly Series of the New York Journal of Medicine.

No. XIII. / Vol. VII. } New Series. NEW YORK: SATURDAY, SEPTEMBER 26, 1863. { *Mail Subscribers, $3 per Ann.* / *City and Canadian, 3 50 "* / *Single Numbers, 10 cents.*

National Medical College.

MEDICAL DEPARTMENT OF COLUMBIAN COLLEGE.

FACULTY.

THOMAS MILLER, M.D., Emeritus Professor of Anatomy and Physiology, and President of the Faculty.
JOHN C. RILEY, M.D., Professor of Materia Medica and Therapeutics.
NATHAN SMITH LINCOLN, M.D., Professor of Surgery.
GEORGE C. SCHÆFFER, M.D., Professor of Chemistry.
JOHN B. KEASBEY, M.D., Professor of Obstetrics and Diseases of Women and Children.
JOHN A. LIDELL, M.D., Professor of Anatomy and Physiology.
JOHN ORDRONAUX, M.D., Professor of Hygiene and Medical Jurisprudence.
*————, M.D., Professor of Theory and Practice of Medicine.
FREDERICK SCHAFHIRT, M.D., Demonstrator of Anatomy.

The Forty-Second Annual Session will begin on Monday, the twenty-sixth of October, 1863, and end on the first of March, 1864.

FEES.

The entire expense for a full course of Lectures by all the Professors is	$105 00
Single Tickets	15 00
Practical Anatomy by the Demonstrator	10 00
Matriculating Fee, payable only once	5 00
Graduating Expense	25 00

No charge for Clinical Lectures.

Payment of the fees is required in all cases, and tickets must be taken out at the commencement of the session.

* This Chair will be filled before the commencement of the Course. For further information apply to

JOHN C. RILEY, M.D., Dean,
No. 453 14th street, Washington.

Long Island College Hospital.—A

Second Class, which is limited to six members, is now forming for the *practical* study of FEMALE DISEASES. The undersigned, having in his clinique from forty to fifty out-patients constantly under treatment, can give to young physicians and advanced students facilities for *direct* and *actual observation* such as are not attainable in any other institution in this country. There will be daily cliniques, at which the members of the class will alternate as assistants in taking notes, writing prescriptions, making examinations, using the speculum, etc., etc. Obstetrical and other cases among the poor of the city are to be had in abundance.

The fee—always payable in advance—for a course of instruction for two months, is $25.00.

E. N. CHAPMAN, M.D.,
Prof. of Clinical Obstetrics and Diseases of Females.
BROOKLYN, Sept. 12, 1863.

New York Medical College and

CHARITY HOSPITAL,

No. 90 East 13th st., near 4th Avenue.

The 14th Annual Course of Lectures will commence on the 19th of October, 1863, and will continue until the first week of March, 1864.

FACULTY.

BENJAMIN I. RAPHAEL, M.D., Professor of General and Military Surgery and Surgical Pathology.
A. JACOBI, M.D., Professor of Infantile Pathology and Therapeutics.
E. NOEGGERATH, M.D., Professor of Clinical Midwifery and the Diseases of Women.
J. V. C. SMITH, M.D., Professor of Anatomy.
WM. F. HOLCOMB, M.D., Professor of Ophthalmic and Aural Surgery.
SAMUEL R. PERCY, M.D., Professor of Materia Medica and Therapeutics.
HENRY G. COX, M.D., Professor of Theory and Practice and Clinical Medicine.
P. H. VAN DER WEYDE, M.D., Professor of Chemistry and Toxicology.
HON. JOHN H. ANTHON, A.M., Professor of Medical Jurisprudence.
STEPHEN ROGERS, M.D., Professor of Physiology.
JOSEPH SHNETTER, Lecturer on Microscopic Anatomy.
JAMES E. STEELE, M.D., Demonstrator of Anatomy, and Curator of the Museum.
JOHN H. THOMPSON, M.D., Prosector to the Professor of Surgery.
F. S. SNEAD, Janitor.

A preliminary term will commence on September 14th, and continue until the regular term begins. The term will be GRATIS to those Students who intend taking a full winter course, and will be as follows:—

On Military Surgery, by	PROF. RAPHAEL.
On Congenital Malformations	PROF. JACOBI.
On Bandaging	PROF. HOLCOMB.
On Ovarian Dropsy	PROF. NOEGGERATH.
On Auscultation and Percussion	PROF. COX.
On Poisons and their Antidotes	PROF. VAN DER WEYDE.
On the Examination of Recruits	PROF. ANTHON.
Demonstrations with the Microscope	DR. SHNETTER.
Anatomy and Physiology of the Kidney	PROF. ROGERS.

Material for dissection is abundant.

Daily Clinics are held at the College.

Further information as to Lectures, Terms, etc., may be obtained by addressing

PROF. B. I. RAPHAEL,
Dean of the Faculty.
No. 91 Ninth St., New York.

PHARMACEUTIC GRANULES AND DRAGEES

(*Sugar Coated Pills*)

of

GARNIER, LAMOUREUX & Co.

Members of the College of Pharmacy, of Paris.

These Granules and Dragees are recognised, both in Europe and in the United States, as the most reliable way of dispensing valuable medicines Physicians will find many worthless imitations, and they must be careful to see that the Pills dispensed by the druggists are made by Messrs. Garnier Lamoureux & Co., members of the College of Pharmacy of Paris. The following are some of the principal preparations:

DRAGEES

	U. S. P.		U. S. P.		U. S. P.
Aloes and Myrrh	4 grs.	Compound Squills	4 grs.	Valerianate of Iron	1 grs
Compound Cathartic	3 "	Dover's Powders	3 "	Citrate of Iron and Quinine	2 "
" "	1½ "	Carbonate Iron, Vallet's formula		" " Iron	2 "
Aloetic	4 "	Carbonate of Manganese and Iron		Willow Charcoal	2 "
Assafœtida	4 "	Kermes	1–5 "	Diascordium	2 "
Aloes and Assafœtida	4 "	Santonine	½ "	Anderson's Antibilious and Purgative	2 "
Dinner, Lady Webster's	3 "	Bi-Carbonate of Soda	4 "	Extract of Gentian	2 "
Compound Calomel, Plummer's	3 "	Magnesia and Rhubarb	1 "	Iodide of Potassium	2 "
" " "	1½ "	Quevenne's Iron Reduced by Hydrogen	1 "	Calcined Magnesia	2 "
Blue Pills	3 "	Meglin	1 "	Rhubarb	2 "
Opium Pills	1 "	Cynoglosse	1 "	Ergot Powder, covered with Sugar as soon as pulv'd	2 "
Calomel Pills	2 "	Proto-Iodide of Iron	1 "	Phyllandria Seed	2 "
Opium et Acet. Plumb. each	1 "	Lactate of Iron	1 "	Washed Sulphur	2 "
Extract of Rhatany	2 "	Sulphate of Quinine	1 & 2 "	S. N. Bismuth	2 "
Compound Rhubarb	3 "	Valerianate of Quinine	1 "	Tartrate Potassa and Iron	2 "
Compound Colocynth	3 "	" " Zinc	1 "		

GRANULES

Of 1-50 *of a grain each.*

Aconitine.	Morphine.	Valerianate of Atropine.
Atropine.	Strychnine.	Veratrine.
Digitaline.		

Of 1-5 *of a grain each.*

Tartar Emetic.	Extract of Belladonna.	Extract of Opium.
Codeine.	" " Hyosciamus.	Proto-Iodide of Mercury.
Conicine.	" " Ipecac.	

Lupuline	¼ grn.	Nitrate of Silver	¼ grn.	Acetate Morphine	¼ grn.
Extract Nux Vomica	¼ "	Extract of Hyosciamus	¼ "	Digitaline	1-24 "
Veartrine	1-24 "	Extract Rad. Aconite	¼ "	Strychnine	1-12 "
Arsenious Acid	1-24 "	Emetine	¼ "	Colchicum (each granule equal to two drops of tincture).	
Sulphate of Morphine	¼ "	Iodide of Mercury	¼ "		
Corrosive Sublimate	1-12 "	Valerianate Morphine	⅛ "		

DRAGEES

Copaiba, pure solidified.	Copaiba, Cubebs and Citrate Iron.	Cubebs and Alum.
Copaiba and Cubebs.	Cubebs, pure.	Cubebs, Rhatany, and Iron.

To be had at the principal Druggists.

Sole wholesale agent,
F. A. REICHARD,
60 John Street.

Original Lectures.

CYANOSIS.

By J. LEWIS SMITH, M.D,

PHYSICIAN TO THE ORPHAN HOME AND ASYLUM, LECTURER IN THE UNIVERSITY MED. COLLEGE.

[Being a Paper read before the N. Y. Academy of Medicine, February 18 and March 4, 1863.]

PART III.

In fifty-eight cases there was an inter-auricular opening, usually the foramen ovale, sometimes enlarged. This opening was ordinarily larger in those cases in which the septum ventriculorum was complete. In fourteen patients the septum between the auricles was entire, in the remaining twenty-five its condition was not recorded.

The ductus arteriosus was absent in eight cases, actually or virtually closed in twenty, open in twenty-four, and its condition not recorded in the remaining forty-five. In those specimens in which the pulmonary artery was rudimentary, the arterial duct often resembled more a branch of the aorta dividing into two pulmonary branches than it did a connecting vessel. In some patients the ductus arteriosus was found in an unusual situation, and this may occasionally have been true in specimens in which it was believed to be absent. In No. 77 it arose from the left subclavian. In Ramsbotham's case (No. 69) there was no ductus arteriosus, but pulmonary branches were found arising separately from the arch of the aorta. In the other specimens in which no arterial duct was found, nothing is stated in reference to the pulmonary branches.

In all the cases there was a communication between the systemic and pulmonary circulatory systems, either by an opening in the inter-auricular or inter-ventricular septum or by the ductus arteriosus. Frequently, two of these communications, and sometimes all three, were present in the same individual. This fact is interesting, as it has an important bearing on the prevailing theories in explanation of cyanosis.

In this malformation it is evident a larger amount of blood than usual enters the aorta, and this vessel consequently becomes enlarged. In those cases in which the inter-ventricular septum is incomplete, the aortic orifice is usually directly over the aperture, so as to receive blood from both ventricles. Occasionally, it is mainly to the left or even to the right of the septum. The semilunar valves of the aorta are commonly enlarged in proportion to the size of the vessel, but in one specimen there were only two valves (No. 43).

From the increased burden thrown on the right side of the heart, the right auricle and ventricle, obeying the common law of muscular development, become hypertrophied. The walls of the right ventricle become so thick as to resemble the left ventricle, and the latter, not receiving the usual amount of blood from the left auricle, does not attain the size or thickness which it presents in the normal heart. On this account it often seems as if the two sides of the heart were transposed. The right ventricle lies more in front than usual, and it forms the apex of the heart.

We have postponed the consideration of the signs observed during life on examining the chest in each kind of malformation, till the malformation was first described, as they can be then best understood. We have already spoken of the frequency of the pulse and respiration, and occasional intermittence of the former. The signs of an abnormal heart were, in a few instances in the above cases, absent or feebly manifest, if the patient were quiet. No evidence, or but slight evidence, of the malformation existed either on palpation, percussion, or auscultation. Commonly, however, there were well marked signs; usually, the systole of the ventricles was stronger than in the normal heart, and often the hands placed on the præcordial region experienced a thrill or vibratory sensation. In many, probably most patients, a murmur or murmurs accompanied the sounds of the heart, and in order to understand the character of this sign the following descriptions will be quoted:—

Case 11.—"A pretty loud murmur attended the systole of the ventricles, but it was not heard over the aorta or pulmonary artery."

Case 34.—"Contraction of the right ventricle louder than usual, and accompanied by a *bruit de soufflet* action of the left ventricle, much embarrassed, feeble in its contraction, and emitting a peculiar flapping noise." This patient was treated in Guy's Hospital, and was examined by Messrs. Addison and Key, who diagnosticated imperfect septum ventriculorum.

Case 35.—"A strong murmur was noticed between the third and fourth ribs, which seemed to extend upwards, and was accompanied by a tremulous sensation."

Case 39.—"A systolic murmur audible over the surface of the heart generally, with its maximum intensity at the base, and extending in the direction of the left costal cartilages."

Case 42.—"Impulse of the heart felt over a large portion of the front of the chest, and attended by a loud murmur audible over the whole of the dull space; dull space extended from the third rib transversely from the right side of the sternum to beyond the line of the left nipple. Murmur most intense immediately below and within the line of the left nipple, and there the second sound was masked by it; was also heard very loudly between the sternum and nipple, and thence towards the middle of the left clavicle; at the top of the sternum it was less distinct, and of shorter duration, so that it was followed by a clear second sound. To the right of the lower part of the sternum there was heard first an imperfect systolic sound, and this was followed by or lapsed into a short murmur, which again was succeeded by a clear diastolic sound."

Case 44.—"On listening over the third cartilage between the nipple and sternum, a soft blowing murmur was heard very distinctly. It was audible, though less intensely, over the whole præcordia, and in a line towards the middle of the left clavicle. It was also distinctly heard to the right of the upper part of the sternum. * * The heart's sounds were heard in the left dorsal region, but the murmur was not there audible."

Case 54.—"Two bruits were heard in the præcordial region. One of them resembled the fremissement cataire, and was heard during the systole of the heart. The other, which appeared to be produced by the contraction of the auricles of the heart, was so clear and loud as to be heard over the whole entire right side of the chest; on the left side it was scarcely perceptible."

Case 60.—"When quiet, the heart's sounds were distinct and free from murmur, but when disturbed, a loud systolic murmur was heard over the whole anterior part of the chest most intensely at the middle and upper part of the sternum."

Case 61.—"A single murmur was heard with the first sound of the heart, most distinct at the apex, present at the base, most feeble in the left infra-clavicular region, most distinct in the right one; the murmur was heard in both infra-scapular regions, but most distinctly in the left."

Case 66.—"A very loud, whizzing, and prolonged murmur accompanied the systole of the heart, and was of maximum intensity at the inferior border of the third left costal cartilage, close to the sternum. From thence it could be traced up the bone for two inches, when it became inaudible. Over the base of the heart it completely masked the first sound. It could not be detected under the clavicle or in the vessels of the neck."

Case 70.—"A loud bellows sound with the systole of the heart, heard most distinctly on a level with the upper margin of the third rib, was heard louder under the right clavicle and not under the left; another bellows sound at

the ensiform cartilage with the first beat; another feebler systolic sound at the apex decreasing higher up the ventricle."

Case 71.—"Had a constant, strong, rasping bruit, accompanying the first sound of the heart, and partially masking it."

Case 87.—"A rough rasping, or sawing murmur, considerably prolonged, accompanied the first sound. This was heard most distinctly on the right side of the sternum, immediately between the third and fourth ribs."

Case 94.—"A very loud, superficial, hissing, bellows murmur was heard in the præcordial region, synchronous with the first sound of the heart. The diastolic sound was healthy or nearly so."

The thrill or vibration which accompanies the action of the heart in these cases, and is communicated to the hand placed over it, is, in the opinion of Dr. Stokes (Diseases of the Heart and Aorta, page 67), produced by the flow of blood through the apertures from the right to the left side of the heart.

It is evident that the same murmur, or rather a murmur produced in the same manner, is described in all these cases, while in some, other murmurs were also present. This murmur is variously described in the records, as hissing, rasping, sawing, flapping, whizzing, and soft blowing. Indeed, the character of the sound appears to have been very different in different patients, but there was usually an agreement in certain particulars. It accompanied the systole of the ventricles, and was commonly most distinct over the base of the heart, but in No. 61, it was loudest at the apex. A writer in the London Medical Times and Gazette, Sept. 10, 1859, referring to what he calls the "basic systolic murmur" in cyanosis, says, "In the great majority of cases it is due, no doubt, to obstruction seated at the pulmonary orifice," and he attempts to show that it is not produced by the flow of blood through the patent foramen ovale. But in No. 11 of the above cases the pulmonary artery was completely closed, so that the murmur could not have been produced in it, and it is therefore probable that it is caused by the flow of blood through the aperture inter-auricular, or inter-ventricular, or both.

The apertures in the inter-auricular and inter-ventricular septa are obviously due to the effect on the circulation, during fœtal life, of the absence or malformation of the pulmonary artery. The blood, being arrested in the right ventricle, escapes at each ventricular systole to the opposite side of the heart, thus preventing the complete formation of the septa.

SECOND MALFORMATION.

Right Auriculo-Ventricular Orifice Impervious or Contracted.

Case 98, M., 21 years.	Case 101, M., 8 years.
" 99, 8 mos.	" 102, M., 4½ years.
" 100, F., 17 mos.	

In the first four of these cases the tricuspid orifice was closed; in the remaining case, it was open, but much contracted. In all, the foramen ovale was patulous, and an aperture existed in the inter-ventricular septum. The venous blood, on reaching the heart by the cavæ, mainly flowed into the left auricle, thence into the left ventricle, from which a part passed into the aorta, and the remainder into the right ventricle to the pulmonary artery. In this malformation there is evidently a very thorough admixture of venous and arterial blood. Dr. Peacock also describes the case of a cyanotic child, seven months old, in whom he states this malformation was present; but as the measurements show that the right auriculo-ventricular aperture was larger than that on the left side, and larger than the pulmonary orifice, it seems to me there must have been some other cause of the cyanosis, and this case is therefore placed in the list of uncertain malformations.

The state of the right auricle is mentioned in three of the above cases, in all which its cavity was enlarged; that of the left auricle is mentioned in two cases, in the one enlarged, in the other of natural size; that of the left ventricle is mentioned in three cases, in all hypertrophied; that of the right ventricle is mentioned in all but one, and in these its cavity was very small, nearly obliterated, but its parietes were of considerable thickness; the state of the ductus arteriosus is recorded in one case only, and in this it was closed.

Nothing is said in any of these cases of a thrill or vibration produced by the action of the heart, and in one only is mention made of a murmur; this was loud, and heard below the left nipple. It is interesting to observe how long life may be prolonged with so serious a malformation: one patient lived eight, and another twenty-one years.

THIRD MALFORMATION.

Orifice of the Pulmonary Artery, and the Right Auriculo-Ventricular Aperture Impervious or Contracted.

Case 103, 15 mos.	Case 106, M., 10 yrs.
" 104, 7 wks.	" 107, M., 15 yrs.
" 105, F., 57 yrs.	" 108, F., 25 yrs.

This malformation consists of the first and second combined. The auricles and the left ventricle are well developed, but the cavity of the right ventricle is small, sometimes almost rudimentary, though its walls are thick and firm. In all of the above cases there was an opening in the inter-auricular septum; in one the pulmonary artery was represented by an impervious cord, and in the remaining five the obstruction in this vessel was produced by adhesion of its valves, between which was a small opening. The ductus arteriosus was closed in three cases, open in one, and in two its condition is not recorded. In three cases there was an aperture in the inter-ventricular septum, while in the remaining three, no mention is made of the septum. In all, the tricuspid orifice was pervious but contracted, and in one, the tricuspid valves were united.

In only one case in this malformation is any mention made of a bruit. In No. 106 it is stated that "an intense cardiac bruit was audible between the shoulders." In No. 105 the thrill or vibration was observed, and in No. 107 the sensation communicated to the hand was like that in hydrops pericardii.

FOURTH MALFORMATION.

Right Ventricle Divided into Two Cavities by a Supernumerary Septum.

Case 109, M., 15 yrs.	Case 115, M., 10 yrs.
" 110, F., 38 yrs.	" 116, F., 20 yrs.
" 111, F., 5 yrs.	" 117, M., 19½ yrs.
" 112, F., 11 yrs.	" 118, F., 20 yrs.
" 113, F., 9 yrs.	" 119, M., 2 yrs. 5 mos.
" 114, F., 5 yrs.	

The supernumerary septum in this malformation is in the infundibular portion of the ventricle, sometimes not far from the orifice of the pulmonary artery; in other specimens, at the distance of an inch or more. It is muscular, and contains a central aperture. In No. 112 the aperture was only sufficient to admit a probe. In No. 111 the septum had undergone the fibro-cartilaginous degeneration on the auricular side. In No. 110 the septum is stated to have been formed of decussating and hypertrophied fibres, and in one specimen the right ventricle was divided into more than two chambers by enlargement of the tricuspid valves (No. 114).

In six of the eleven cases in this malformation the pulmonary artery was small or contracted at its orifice; in two this vessel was natural; in one its size was greater than that of the aorta, and it was furnished with four valves; in the remaining two cases nothing is said in reference to it, but in one of these last its orifice was probably small, as it was furnished with only two valves. In two of the contracted arteries there were also only two valves, and in one no valves at all.

Dr. E. Lee Jones has been appointed physician for the treatment of officers of the army in New York City, in place of Dr. Hammond, Surgeon U. S. Army, detailed to temporary duty at Charleston.

Original Communications.

BAYONET WOUNDS, WITH CASES.

By JOHN A. LIDELL, Surg. U.S.V.,

IN CHARGE OF STANTON HOSPITAL, WASHINGTON, D.C.

Guthrie says, "a great delusion is cherished in Great Britain on the subject of the bayonet—a sort of monomania very gratifying to the national vanity, but not quite in accordance with matter of fact. Opposing regiments, when formed in line and charging with fixed bayonets, never meet and struggle hand to hand and foot to foot, and this for the very best possible reason, that one side turns round and runs away as soon as the other comes close enough to do mischief." A similar delusion is widely spread in this country. The truth is, that wounds inflicted by the bayonet have been of comparatively rare occurrence in every war that has scourged the earth since the invention of that weapon. And the war in which our Government is now engaged for the preservation of its existence is not an exception to this rule.

In all, *three cases of bayonet wounds* have come under my notice since the war began. One case was that of a soldier belonging to the 106th Regt. Penn. Vols., who was wounded in the upper part of the thigh with a sabre bayonet, during a skirmish of pickets with the enemy, a few days after the battle of Fair Oaks. The femoral artery was divided, and he died of hæmorrhage before assistance could reach him. It is probable, however, that he was wounded accidentally by a comrade and not by the enemy. The other two cases are herewith reported.

I. *Bayonet Wound of Right Thorax.*—Corporal Thomas, Co. "G," 2d U. S. Infantry, aged 40, constitution sound, was stabbed by a bayonet in the hands of a refractory prisoner, Dec. 2d, 1862.

Bayonet entered one-half inch to the right of the median line of the chest, immediately next to the middle of the xiphoid cartilage, penetrating four inches in a direction downwards and outwards, entering the chest over the costal cartilages of the eighth, ninth, and tenth ribs. The surgeon who saw him at that time says that, "on receipt of injury, prostration, vomiting for two days, difficulty of breathing, incapacity of drawing a long breath, total absence of movement of ribs of lower part of the right chest, decubitus on injured side, no spitting of blood, no blood from external wound, no respiration heard on lower part of right chest, puerile respiration above and over the whole of the left chest, mixed however in some parts of the left chest with mucous sounds of bronchitis; gentle stimulants and essence of beef for first day and no drugs; from second to fifth essence of beef only; sixth and seventh day rice, tea-soaked biscuit and essence of beef.

Second physical examination on Dec. 5th: Lower part of left chest dull, beginning to hear sub-mucous rhonchus and small crepitation. Cough less, altogether better, an evacuation without medicine. Vomiting ceased. Dec. 7th: sat near fire twice during the day for half an hour each time. Dec. 8th: third physical examination: lower ribs of right side begin to move in act of breathing, breathes easier, less pain, moist sounds heard over a larger space, do not find small crepitation, no bronchial respiration and voice, upper part of right lung not so labored in respiration; sleeps better; coughs but seldom, no sputa, no fever; sits by the fire for an hour at a time." The foregoing history is copied from the account of his case sent forward with the patient by the surgeon who first treated him.

He was admitted to Stanton Hospital, Dec. 11th, 1862. At that time the wound was closed and the orifice of it covered over by a small dark colored triangular-shaped scab. He complained much of darting pains and stitches in the right side. He exhibited dyspnœa and increased frequency of the respiratory movements, together with "catches" in his breathing. At times the dyspnœa was so great as to compel him to sit up in bed; decubitus on the injured side. The physical exploration showed that there was a moderate amount of effusion in the cavity of the right pleura, with friction sounds ("to and fro" sound) higher up on the same side.

He was directed to keep quiet in bed, to be supported by a nourishing diet, to take fluid extract of cinchona combined with iodide of potassium, and, with a view to still further promote absorption and combat the traumatic pleurisy, to have a succession of blisters applied to his right chest.

About Christmas he had a severe exacerbation of all his symptoms, which was combated by the application of cups, both wet and dry; and again a fresh pleurisy was lighted up in the early part of January, 1853, which was combated in the same way. We now began to suspect that the effusion was purulent (more or less) in character. He did not exhibit hectic fever. Under the tonic and supporting plan of treatment he slowly mended in spite of the relapses, and by the 25th of January he was able to be up most of the time. He was put upon the use of quinine and iron instead of potass. iodid. and cinchona, about this time. He continued to slowly improve, and was discharged from the service on surgeon's certificate of disability, at his own request, February 2d, 1863. He was still very feeble and wan. He still had dyspnœa, and percussion showed that the pleuritic effusion, although diminished in quantity, still remained, but the dyspnœa appeared to be much greater than could be accounted for satisfactorily by the amount of the effusion. We have received no tidings from him since he left the hospital. He will probably succumb sooner or later to the chronic traumatic pleurisy, exhausted after repeated exacerbations of the same.

II. *Bayonet Wound of Left Thigh.*—Sergt. J. T. C., Co. H, 105 Regt. N.Y. Vols., was wounded at the last battle of Bull Run by a bayonet in the hands of an enemy: command was advancing in line of battle in the woods near the railroad, when the enemy charged unexpectedly, and the command was forced to fall back.

The bayonet entered the front of the left thigh in Scarpa's space, about three and a half inches below Poupart's ligament, and passed directly backwards close to the femoral artery: patient thinks the bayonet struck the femur: wound did well and healed without any difficulty in about six weeks, patient remaining with his command all the while.

On examination, January 15th, 1863, I find a small cicatrix, triangular in shape, on the front of the left thigh, about three and a half inches below Poupart's ligament, and lying directly over the femoral artery: and palpation detects considerable consolidation of the parts underneath, such as we would expect to follow the healing process of a bayonet wound extending to a considerable depth into the thigh.

Washington, D.C. Sept. 13th, 1863.

PYÆMIA OR LEUKÆMIA.

By GEO. R. WEEKS, Surg. U.S.V.,

IN CHARGE OF U.S. GENERAL HOSPITAL, MEMPHIS, TENN.

Having recently been much interested in the various pathological conditions resulting in pyæmia, leukæmia, or leucocythemia, and believing that I have observed some facts of interest in this disease, I submit the following observations taken at the bedside, and with a view of establishing the true nature and conditions found in those affected by this particular grade of action. If I can be able to contribute in the least to this end, I shall feel myself amply rewarded. I believe it closely allied to hospital gangrene, and it generally has appeared to be the sequence of this disease.

The ideas that I shall present were taken in the observa-

tion and treatment of cases of gangrene, in all 175. 115 of these were observed and reported on at Louisville, Ky., 6 occurred in 17th Army Corps Hospital at Vicksburg, Miss., and 54 at this hospital during the month of August, and with what result will be shown in the following summaries:—

SUMMARY OF CASES TREATED BY BROMINE LOCALLY, AND THEIR RESULT.

No. treated,	146
Recovered,	134
Died,	12
Died of Gangrene,	0
" Pyæmia,	3
" Thrombus and sepsis of the blood,	5
" Mechanical pneumonia,	2
" Cellulitis,	1
" Diarrhœa,	1
Flesh wounds,	104
" bone involved,	42
Average time of arrest,	4·26

SUMMARY OF CASES TREATED WITHOUT BROMINE, AND THEIR RESULT.

No. treated,	29
Recovered,	20
Died,	9
Died of Gangrene,	4
" Pyæmia,	3
" Thrombus and sepsis of the blood,	1
" Mechanical pneumonia,	1
" Cellulitis,	0
" Diarrhœa,	0
Flesh wounds,	24
" bone involved,	5
Average time of arrest,	18·8

Fifty-three of these were treated locally by pure bromine, average time of arrest being 1·92 days, seldom requiring the second application. Ninety-three were treated by comp. sol. of bromine, average time being 8·66 days; and in those treated by the usual methods, the average was 18·8 days. Both had the same constitutional treatment, and were alike situated in other respects.

All the facts noticed during the management of these cases point to the following views in regard to its pathology:—That hospital gangrene is produced by a *specific animal poison*, and that it only enters the system by inoculation upon a traumatic surface. That for a variable time after it is deposited upon or in the sore it is local in character; after which time it enters the blood through the absorbent system, and changes its constituents both vitally and chemically. I have designated this the stage of toxæmia, and this morphologically changes the blood; the result is thrombus, which in my opinion is the plastic portion aggregated and semi-organized, necessarily rendering the remainder aplastic and of little use to the economy in the work of repair. I have many morbid specimens now in my possession that clearly substantiate the truth of these different stages. In illustration of which allow me to cite a few cases.

I.—Adam Brangle, Priv. 1st U.S. Inf., was brought to the 17th A. C. Hosp., of which I had charge, with gangrene of the right arm, which had been amputated previous to his admission some time. Upon auscultation, I diagnosed mechanical pneumonia of the right lung; he complained of pain in the heart and over the lower lobe of the right lung, which gave a flat sound, and with entire loss of vesicular resonance; *no crepitus was heard in the part or above it.* I treated the arm locally with pure bromine, which arrested the gangrene promptly, and the sore continued to granulate till near death, but the pulmonary difficulty continued upwards until the entire right lung was involved, and half of the left, when he died. I examined him carefully, and noted his symptoms three times a day myself as long as he was under my care.

Autopsy, twelve hours after death.—The right lung was very much enlarged and heavy; it readily sank in water; so large that it filled the right side of the thorax entirely; upon section, it presented innumerable dark-colored points of all sizes, which were followed back to where they could be unmistakably seen to be in the pulmonary artery. I hazard little by saying that very nearly all the vessels in the right lung were occluded by thrombi, also a portion of the left, and in none of them were there any signs of a *retrograde movement, or softening.* This was a rapid case, and one that finely illustrates the mode of dying, which was undoubtedly obstruction of a purely *mechanical nature*, so far as the lungs were concerned, producing an excess of carbonic acid in the blood, and deficiency of oxygen from pressure on the vessels and obliteration of air-space. This is the first stage, or one *necessary* link in the pyæmic process.

II.—James A. Beaver, Priv. Co. A, 33d Iowa Inf. Vols., was admitted to this hospital July 30, 1863, with gangrene of the ankle, involving the instep and ankle-joint. I examined him Aug. 8th, and diagnosed thrombus and septic poisoning, and made an unfavorable prognosis. This was the first day after being assigned. Gangrene was existing since July 17th, which was arrested by the use of bromine locally Aug. 12th, but no repair was established. The wound kept clean, and had no fœtor. He died Aug. 18th.

Autopsy ten hours after death.—Lungs filled with a dark-colored semifluid substance in the vessels, and at points portions of unsoftened thrombi yet remained; in some of the larger vessels it was still entire; at some points where the pressure was greatest, softening had commenced in the parenchyma, always most advanced in the part nearest the vessel. I found a large thrombus in the left side of the heart, more than half of it softened, and softening the walls of the heart with which it was in contact, looked of a purple color, had a *gangrenous odor*, and was easily broken down between the thumb and finger, upon moderate pressure. I take it that this case points to the transition state from thrombus to true pyæmia, and marks the process quite clearly. Death perhaps was brought about by Ichoræmia, depraved or perverted nutrition, caused by the septic condition of the blood, whose morbid element was indebted to softened thrombi, and whose product returned to the general circulation, rendering it more poisonous.

3rd. J. S. H. Sutton, Priv. Co. I, 36th Ind. Inft. Vols., passed through both the above mentioned stages, and died from the next, or true pyæmia. Metastatic abscesses were formed in the lower lobe of the right lung of all sizes, from a millet seed to that of a walnut, and also *thrombi, entire, and softening* in the *same* lung, forming new centres for abscesses. This man had been sick a long time, and had gangrene in the popliteal space, which had been arrested previous to death some considerable time, but not in time to prevent ichoræmia. I cite these three cases as marking the stages leading to the state of pyæmia, distinctly and clearly. I have endeavored to present the facts as I observed them in these cases, and let the results follow. Post-mortem appearances are nature's teachings, before whose power our most subtle theories and ingenious hypotheses bow in humble submission.

I have examined all that died, in every one of which I have found *thrombus in the heart and lungs*, in some of the stages before mentioned, until I am inclined to look upon them as a necessary condition, and am fully persuaded that Virchow is right in calling it Leukæmia, as I shall endeavor to prove by and by. These remarks are not only true of gangrene, but are equally so of all that class of diseases arising from blood-poisoning, in which also ichoræmia secondarily plays an important part, and I am not sure but that it will enable us to explain all the phenomena presented. Their accompanying symptoms are very analogous to those arising from the effects of the bite of a venomous serpent, and perhaps what will cure one will arrest the other.

I said in the commencement, that primarily I believed it to be local, and that it passed into the blood by the agency of the absorbents, when toxæmia was produced, but how is this brought about? in what manner are those changes produced? I answer—1st. By contact of the morbid product with the traumatic surface. 2d. Transformation of *cell content*, which I am induced to believe is an impression made by oxydation upon the tissues. 3d. Absorption of the ichorous product, which causes a retrograde movement in the part, and also in the constituents of the blood, which I think is chemico-vital in character, and right here, the corpuscular change is quite apparent by the aid of the microscope. The red corpuscle loses its hæmine, which, becoming granular, is deposited in a circle, and aggregated around the outside of the field. The white corpuscles are very abundant, and occupy the whole surface. Crystals of ammoniacal salts are found in abundance, and an occasional fungus may be seen. Virchow has shown that it is not possible for substances or rather particles of matter to pass through the lymphatic glands, but as in the case of cinnabar, or tattooing, they are arrested, and detained there. I cannot say *how* it is accomplished, but the fact that the morbific agent *does* pass the glands, and as these are the last row of sentinels to contend against, I can see no reason why it should not proceed onward to the blood. I have a case in point. Priv. James Scott, 1st Mo., Co. A, died at this Hospital on Sept. 3d, in whose *thoracic duct* I found a well developed *thrombus*, and sent it to Surg. Brinton, U.S.V., Washington. It was about four inches long, and largest in that portion that occupied the receptaculum chyli. It is the first case that I have ever seen or heard of.

The glands were enlarged, indurated, and of a dark color, as if filled with pigment granules, which I very much suspect they were. The ichor undoubtedly had passed them. If so, the whole process corresponds very nearly to Virchow's idea of their function. This case conclusively proves *three very important facts*, viz. *That the poison, whatever it is, passes through the lymphatic glands; that it is capable of producing thrombus on the other side; and that the morbid element does not reside in the pigment but in its ichor.* I am of the opinion that this settles a vital point in the pathology of Leukæmia.

The death of the part affected by gangrene is a molecular one, and I believe should occupy an intermediate position between ulceration and mortification. It is always accompanied by asthma. Of the cases observed here during the month, the average temperature of the body was 89° Fahrenheit, and the number of pulsations was 101, which significantly points to the manner in which they die, and to the indications for treatment.

In the formation of thrombus, I have invariably found them of the shape of the vessels upon the right side, and globular upon the left, and seldom extending into the vessels. I have one of the left auricle now, weighing 482 grs., and one representing every branch of the pulmonary artery, which had its attachment to the right ventricle.

It will be inferred from what I have before stated, that I regard the disease as curable, before its consequences are constitutionally developed. This is exactly what I at present believe. I can see no reasonable prospect of reaching it, and would not know how to make a rational prescription with my present views of its pathology, other than support when it once becomes general. Upon the appearance of thrombus in the heart and lungs, which is easily detected by the physical signs, hope with me ceases; some may recover, but I have not seen them.

The rational remedies indicated, I believe to be oxygen, fluorine, chlorine, bromine, &c. I should expect much from the former, and shall try it as soon as I can. Fluorine is too destructive; chlorine can only be obtained in a fluid state under great pressure, or in the form of mechanical mixture, hence the selection of bromine, which is in the best form, and easiest of application, and over which condition I believe it to have a *specific* influence. I am of the opinion that it will arrest gangrene wherever it can be brought in contact with *all* the pulp, or pultaceous matter; this frequently is very difficult to do, in the burrowing form of the disease, also from the nature of some wounds it is nearly impossible to get at every part.

When the full importance of the *general condition* was observed by me, I resolved to use the protosulphites internally; they did no good; bromine was then tried (3 drops comp. sol. three times a day), but with a like result. I am again putting it to a severe test in all cases under treatment here in the following form: R. Bromini comp. sol. ʒ ij., aquæ destillatæ f. ℥ ij., Syr. Simpl. ʒ ij. M. One drachm three times a day. I am favorably impressed with it so far, but cannot speak yet with any certainty.

A NEW UTERINE PORTE CAUSTIQUE.

BY FREDERIC D. LENTE, M.D.

An efficient uterine porte caustique by which the nitrate of silver may be applied thoroughly to the whole extent of a diseased cervix, or to the interior of the body of the uterus, has long been a desideratum. Every physician who has been in the habit of treating diseases of the uterus to any considerable extent, and especially by local medication, must have experienced constant annoyance from the difficulty of making applications with any of the appliances hitherto recommended. It is probably to this cause more than to any other that the intractable nature of chronic inflammation of the cervix (cervical leucorrhœa) is due. I have found the little instrument here represented by far the simplest and most efficient means of applying nitrate of silver to the cervix and body of the uterus, of all the contrivances that I have seen. It has been tried by a large number of physicians in New York, Boston, and other cities, and has given great satisfaction. I have therefore ventured to recommend it publicly to the profession. It is simply a long silver probe attached to a handle, with an olive-shaped enlargement an inch and a half from its extremity; the whole instrument should be just ten inches in length. The enlargement is for the purpose of showing when the extremity has reached the internal os, so as to prevent the caustic from touching the interior of the body of the womb when this is not advisable; if it is to be passed into the body, the enlargement will offer no resistance. It is armed with the nitrate by melting the latter in any convenient vessel; then, after having *cleaned the end thoroughly*, and *heated it moderately* in a *spirit lamp*, by dipping it repeatedly in the liquid caustic, after it has cooled a little, until a sufficient coating is lodged upon it. In applying it expose the os with the bivalve or with Sims's speculum, pass the sound to get the exact curve and direction of the cervical canal; bend the end of the probe to correspond, and then it can be passed directly to the internal os, or to the fundus, without losing any of the caustic in exploring, or unduly irritating the cervix. Just so much of the nitrate may be placed on the probe as may be thought necessary to leave in the uterus; it may be rubbed over the whole diseased surface repeatedly and firmly, and withdrawn, without any danger of detaching it from the probe, if the above directions are observed. The instrument may be had at Tiemann's and at Otto and Reynders's.

Coldspring, September 8, 1863.

Dr. J A. Douglass, Associate Secretary of the Sanitary Commission, has gone to Charleston on the business of the Commission.

Dr. J W. S. Gouley, Assist. Surg. U.S. Army, has been ordered to examine the Enrolling Records in the first ten districts of the State of New York with a view to establish uniformity in the medical examinations.

Reports of Societies.

AN INTERESTING CASE OF BLACK VOMIT,

WITH DISCUSSION AS TO ITS ETIOLOGY.

[Presented to the Kings County Medical Society.]

By J. T. CONKLING, M D.

(*Concluded from page* 196.)

REMARKS BY DR. D. C. ENOS.

Dr. E. said he saw the patient in consultation with Dr. Conkling. He thought the case was an obscure one, presenting some of the phenomena of yellow fever, while many of the symptoms of that disease were altogether absent. The only prominent symptom of yellow fever was the black vomit. Doubtless, as Dr. Bell says, this is the most pathognomonic of all the symptoms of yellow fever; but it would be as erroneous to assert that every case of black vomit is one of yellow fever, as it would be to maintain that yellow fever could not occur without it. When speaking of black vomit, Dr. La Roche says, "considered by itself, without reference to other phenomena by which it is preceded and accompanied, and especially when noticed in a *single* or *a few sporadic instances*, the black vomit is not sufficient to stamp the disease in which it occurs as being the true yellow fever. While, on the other hand, its occurrence in this disease is not sufficiently constant and necessary to justify us in refusing to recognise as such cases which present its other symptoms, merely on the ground that black matter has not been ejected from the stomach." His citations from the best authors to prove both these propositions are ample and conclusive, covering fifteen pages of his great work on yellow fever. Hence, if the case detailed be one of yellow fever, in order to establish it beyond a doubt, the antecedent history, concomitant symptoms, and post-mortem lesions, must give the necessary corroborative evidence. What is their testimony? To determine this question properly, the points of the case which do not assort, as well as those which do, with the known phenomena presented by yellow fever, could be noted.

Some of the facts in this case which do not agree with those *most generally present* in yellow fever, are :—

1st. *The period of incubation was longer.*—The best authorities say the stage of incubation ordinarily varies from a few hours to five or ten days—*occasionally, but very rarely*, to sixteen, twenty, or more days. In this case it was at least nineteen days, and doubtless more, for, as Dr. La Roche says, it is not probable he took the poison the very day he left. His history as given, though not incompatible with yellow fever, still offers no *presumptive evidence* in favor of such a theory, but rather the reverse, since this compatibility itself requires to be established by the most unequivocal evidence that the case was one of yellow fever, its symptoms and its lesions being incapable of any other interpretation. Such a case being made out the mind would be compelled to believe that the man passed in an uninfected ship, this, to say the least, unusually long period of incubation; that he and he alone took the disease at Kingston or Port Cabello, and at a time when it was not prevailing in either place; that in mid-winter he must have taken the malady from its slumbering dregs or from its nascent causes, which it is said "are never effectually banished from tropical seaports."

2d. *It was not ushered in with a chill.*—"There is probably no disease," says Bartlett, "unless it is puerperal peritonitis, the access of which is more *invariably attended* by a chill or rigor than this."

3d. *Pain in the head was absent.*—In yellow fever, according to the same authority, it is almost invariably present—"generally it is acute and violent." Mr. Pym says, "The most characteristic symptom of the disease is the peculiar pain in the forehead and eyeballs, with the drunken appearance of the eye."

4th. *The patient had severe pains in his bowels*, and not in his back, loins, and limbs, which are generally so constant and intense in yellow fever.

5th. *The color of the skin was normal.*—"In fatal cases of yellow fever, yellowness of the surface is almost always present."

6th. *The eyes were not suffused, injected, or yellow*—symptoms, some or all of which usually occur in the course of fatal cases, at least, of the genuine typhus icterodes.

7th. *The patient had excessive thirst*, which Sir Gilbert Blane says is not *usually* the case in yellow fever,—so say Bally, Jackson, Chisholm, Clark, and Dr. Lewis, of Mobile.

We have then the highest authority for believing that all these symptoms are *generally* present in yellow fever. Cases, however, do occur, in which one or more of them are absent, but rarely, if ever, in which all of them are.

These are some of the facts which, during the progress of the case, led Dr. E. to doubt that it was one of genuine yellow fever, notwithstanding the presence of the copious black vomit, which was so acid that it excoriated the fauces, and notwithstanding the constant uneasiness and jactitation of the patient, which are generally so characteristic of the disease. This doubt the post-mortem examination so carefully and so creditably made by Dr. Spier fails to remove.

The livid tinge of the surface which he describes does not equal "the yellow color varying from a pale or light to a dark orange or brown tint," which La Roche says is generally present:—"Sometimes it is greenish, mahogany, leaden, purple, or black." The lungs were engorged with black, as they sometimes are in yellow fever, though Drs. Physick and Cathrall (1793) found the lungs perfectly sound; so as a general thing did Harrison, La Roche, and others. Not unfrequently, however, the lower portions of the lungs are engorged with altered blood. This is frequently so in other diseases characterized by blood dyscrasia. The *dark clot* found in the right cavities of the heart in this case is like that frequently found in yellow fever, though Bally and Pinnell found it of a light amber color. The dark clot is also found in other diseases. The stomach contained the same dark fluid as that vomited, so did the intestines.

Dr. Bell relies mainly on fatty degeneration of the liver as the "pathognomonic lesion" of yellow fever. This is unfortunate for his diagnosis in this case, for the liver was not fatty in the true sense of the term. Dr. E. said he examined the hepatic cells and tissue with Dr. Spier. The cells were unusually normal—less fatty than those of any liver examined at the B. C. Hospital, in the last six months. A few cells contained a little more than the normal quantity of fat, but this can be found in most livers and in various diseases. Hæmatoidin was found abundant in the hepatic tissue, which Dr. Clark says is not found in yellow fever. The liver had not the yellow color so much insisted on by Louis, as the *peculiar* condition in yellow fever, and which is now supposed by some to be owing to acute fatty degeneration. M. Catel says, of 150 cases of yellow fever, all the livers were abnormal in color—discolored, and yellow, fawn, or drab. Dr. Spier says, this liver was very dark, between a purple and a chocolate, with a few patches on the anterior part a little lighter—slightly yellow in tint. The general and microscopic appearance of this liver, then, is unlike that usually seen in yellow fever. The *spleen* was *very soft;* whereas in yellow fever, says Bartlett, it is not the seat of any frequent and important alterations. Louis and Trousseau found it somewhat softened in about half the cases. Dr. Bache, in two out of ten. Dr. La Roche says it is often little, if at all, changed. The kidney was not degenerated, as in Bright's disease. The urine was scanty, though he passed it, he said, the evening before Dr. Conkling saw him. That found in the bladder was albuminous. It is scanty or suppressed in yellow fever; so it is in cholera, or in any disease

in which the fluids are passing off rapidly by the skin, or, as in this case, by the gastro-intestinal mucous membrane. The albumen was due to the presence of blood in the urine, as proved by the microscopic examination. The kidneys were congested, but normal in *size* and structure. Dr. Pinnell says, in fatal cases of yellow fever the kidneys are in a condition like that witnessed in Bright's disease. Dr. Blair met with only a few cases of *bloody urine* in yellow fever. He regarded it as a favorable symptom.

The muscular fibres of the heart were perfect. In yellow fever Prof. Riddell found them degenerated, all traces of striation having disappeared.

Dr. Bell said the "liver was just beginning to be discolored," "that fatty degeneration had but just commenced." This may be so, but it hardly answers the purpose of a "pathognomonic" diagnosis. We cannot well say what it was about to do; all we can say, in point of fact, is, the liver was *not* fawn-colored, it was *not* in a state of fatty degeneration. We might as well say the kidneys were in the same morbid condition, because, though otherwise sound and healthy, a few of the tubuli uriniferi were bereft of their epithelium. So far as the heart is concerned, there is no room to predict that any such process was about to take place, for the record is, its "structure was perfect." The molecular disarrangement of the cardiac muscular fibres, which Prof. Riddell found so constant in yellow fever, had *not even commenced.*

Hence, from all these facts, Dr. E. inclined to think the case was not one of *genuine yellow fever.* He expressed this doubt with some hesitation, on account of the positive opinion of Dr. Bell, coincided in, it seems, by the distinguished author of the letter he read. It is proper to remark, however, that Dr. La Roche did not see the patient during life, nor witness the examination of the body after death.

Dr. Bell's explanation of the imperfection of the symptoms and lesions in this case is its "fatal rapidity," which, he says, is usual in climates where yellow fever rarely occurs; "since," he remarks, "the organism is deprived of a gradual adjustment to the influence of the poison, on the same principle as that a vigorous bird speedily perishes in an atmosphere which will sustain one gradually brought under its influence for a much longer time." But surely we must believe that any bird, whether slowly or suddenly brought into a poisonous or foul atmosphere, will live longer or die more gradually when *totally removed* from such atmosphere. Again, supposing this to have been a case of yellow fever, there was ample time for the system to "become adjusted to the influence of the poison." Indeed, this was so ample as of itself to make it rather improbable that the patient had the disease at all.

If not yellow fever, what could this disease have been? It may not be easy to determine this, and assign the proper name. Isolated cases frequently occur which defy nosology. Could it have been the effect of bilious remittent fever? This the patient said he had at Kingston. We shall show that black vomit sometimes occurs in this disease, and that the post-mortem lesions, as a whole, agree better with the pathology of bilious remittent than they do with that of yellow fever. Black vomit occurred in the bilious remittent fever in New York in 1843 in the Hospital, and at Yonkers (*Forrey on Rondout Fever, N. Y. Jour. of Med.*, vol. i. p. 340). Dr. Dickson (authority none will question) in 1825 saw two patients die of bilious remittent fever, on Charleston Neck, who ejected black vomit from the stomach and bowels. He also saw cases in 1827 (*Essays*, i. 355). Dr. Fenner, of New Orleans, saw two cases of it in 1850 (*South. Med. Reports*, ii. 89). Both these authors, let it be remembered, were familiar with yellow fever. Cleghorn saw black vomit in the tertian fever of Minorca, a disease more unlike yellow fever than bilious remittent is. In the Batavian fever, which was a bilious remittent, Dr. J. Johnson said patients sometimes have black vomit, and occasionally after lingering twenty or thirty days. This occurred also, he says, in the Bengal remittent. Trousseau, Lancisi, Garnier, Imray, and others, refer to the occasional occurrence of black vomit in bilious remittent fevers. Dr. La Roche "has seen an interesting case of copious ejection of well marked black vomit occurring in a fatal attack of colic." It will be recollected in this connexion that Dr. C.'s patient *had great pains in his bowels*, and not in his back, loins, and limbs, as in yellow fever cases. Enough has been said to show that black vomit may occur in bilious remittent fever, even a month after the first attack.

Some of the post-mortem appearances in the case under discussion are more consonant with bilious remittent fever than with yellow fever. The spleen was very soft and friable; Dr. Spier says it was "diffluent." Dr. La Roche remarks that, while the spleen is but little if at all changed in yellow fever, in bilious remittent "it is very generally much enlarged and *softened.*" Dr. Spier says the liver was very dark, between a purple and a chocolate color. This description agrees tolerably well with the so called "*bronze liver*" of bilious remittent fever. This color, Dr. Alonzo Clark says, is owing to altered *hæmatine*, which Prof. Virchow named *hæmatoidin.* This coloring matter is not in the cells, but in the hepatic tissues. Dr. Spier's drawing well illustrates this. He found the liver well supplied with hæmatoidin. Profs. Clark, Leidy, and Dr. La Roche say, that, though this modified hæmatin is found in black vomit, it has not been *found in the liver of yellow fever.*

This liver agrees with that of bilious remittent fever in another point. We have already seen that it was but little, if at all, fatty. Prof. Clark, in his letter to Dr. La Roche on the "Bronze Liver," says, a deposit of oil globules in the cells and tissues of the liver is *not so frequently met with, nor is it so abundant in remittent as in yellow fever.* In this letter he also makes an interesting remark on the duration of the coloring matter in the bronze liver. He said, "he had examined the livers of two persons who had had remittent fever a year or more before their fatal sickness. In both the remittent color remained well marked, though less intense than in recent cases. The microscope disclosed the coloring matter unchanged, except, perhaps, in quantity."

Dr. Spier found the hæmatoidin not only abundant in the liver, but also in many other organs and tissues. This shows how profoundly the blood was modified. The minute and thorough examination made by Dr. Spier, without reference to any theory, has done much towards clearing up the difficulties of diagnosis in this interesting case.

From a careful review of all the facts before us, the most plausible theory of the process of the disease appears to be this. That the patient had, as he alleged, at Kingston, bilious remittent fever which confined him to the hospital several weeks—that for two weeks after leaving the hospital he was imperfectly nourished, his diet being *bread and salt fish;* he did not regain his strength. That though he worked his passage to Philadelphia he was all the while very feeble. Arriving here he dined on corned-beef and cabbage; he vomited in the evening. Next day he took salts and cream of tartar, which caused vomiting and purging; in the evening the ejected matters were copious, acid, and dark-colored. This continued at intervals for thirty-eight hours, when he died. It is probable that the *bilious remittent* fever caused the morbid changes in the blood and in the tissues from which Nature was feebly trying to rally—that the last fatal illness was excited in his enfeebled and altered organism by the ingesta which he took, and by the medicine which was given him.

Dr. Bell added, that he thought no one could justly infer from his previous remarks that black vomit necessarily indicated yellow fever, or that it alone was sufficient to stamp a case of disease as such. In addition to what he had said of the symptoms wanting in this case—headache, backache, aching of the extremities, etc.—these, like jaundice, are not unfrequently absent in rapidly fatal cases, in relapse, or in cases enfeebled by other recent disease. There were several such cases among the invalid soldiers

under his care last summer. One, in particular, had been sent from the Tortugas on account of dysentery, and at the time he was received into the Floating Hospital his only complaint was an increasing debility. He gradually sank, and died with black vomit in eighteen hours, without other prominent symptoms. There was no question in this case, because the steamer *Delaware*, in which he arrived, was known to be badly infected. Another case also, an invalid from *intermittent fever*, died in twelve hours from the time of attack, with six hours of black vomit. Both of these cases had fatty degeneration of the liver—in one the liver was yellow, in the other it was livid. Besides such cases as these, there is a class of yellow fever patients known as walking cases, which generally die with black vomit within a few hours from the time they come under observation, and are not usually characterized by chill, headache, or other prominent symptom. Yet they are accepted as true cases of yellow fever.

The case under discussion appears to have been rapidly fatal on account of relapse or other previous cause of debility. It may have been bilious remittent fever, though we have no evidence of this, other than that the patient himself stated that he had that disease at the time when, and the place where yellow fever is known to have been prevailing. The period of incubation is no index of the duration of the disease, nor of its severity, while it is nevertheless highly probable that the fatal issue in this case was promoted by the change from the high temperature where it was contracted to the low temperature under which the poison became active.

That a certain period of incubation, chill, pain in head, back, and extremities, jaundice, suffused and injected eyes, and *absence* of thirst—"that *all* of these symptoms are *generally* present in yellow fever"—is contrary to both his observation and his reading; and further, that according to a somewhat extended observation of bilious remittent fever in hot climates, he believes most of these symptoms to be quite as essential to "bilious remittent fever" as to yellow-fever. But of black vomit as a symptom, whether existing almost alone, as in this case, or in connexion with other symptoms, it is certainly much less characteristic of bilious than of yellow fever under any circumstances whatever; and he is therefore wholly unable to see the propriety of taking this symptom to indicate a disease in which it very rarely occurs, rather than one in which it very commonly occurs.

In addition to what has been said of the pathology of the case, it is certainly quite as reasonable to find "a few cells in process of fatty degeneration," and to infer, therefore, that this lesion has but just commenced, as it is not to be satisfied with anything less than the degree of fatty degeneration common to the drunkard's liver in hospital practice.

The presence or absence of hæmatoidin may depend upon the degree of disorganization of the blood corpuscles. This is a recent question in yellow fever, and requires further investigation. The other exceptions of Dr. Enos are abundantly answered by the authority quoted—Dr. La Roche.

Sir Henry Holland, physician to the Queen of England, is on a visit to Washington.

Dr. Henry W. Williams, of Boston, has returned from a European visit. He has communicated his observations on European ophthalmic institutions to the Boston *Medical Journal*.

Dr. J. J. Chisolm, Med. Purveyor of the rebel army at Charleston, publishes the following card:—*Silver Plate Wanted.*—To be converted into caustic for the use of the sick of the army. $8 per ounce will be paid for all prime plate. Old spoons and old plate will answer the purposes of the medical department as well as new. Apply at Medical Purveyor's office, opposite Congaree House.

American Medical Times.

SATURDAY, SEPTEMBER 26, 1863.

REMOVAL OF SLAUGHTER-HOUSES.

New York has at length secured a City Inspector, who, at least, seems to have a regard for its sanitary interests. Whatever may be the motive that inspires his official acts, it is very evident that Mr. Boole is doing more effective work in his department than has been done during the last twelve years. He not only desired to have clean streets, but he set the machinery to work and had them cleaned very thoroughly; and he steadily and perseveringly labors to perfect arrangements whereby they will be kept clean. His last and most important effort has been, to effect the removal of the slaughter-houses beyond the city limits. This is a task which few would have the courage to undertake, both on account of its magnitude, and the vast pecuniary interests concerned.

We may gain some idea of the extent of this nuisance from the following figures. There are at present 223 slaughter-houses located in various parts of the city, of which number 76 are on the west side, and 147 on the east side. They are distributed as follows: In the Ninth Ward there are 26, in the Twentieth Ward 21, and in the Twenty-second Ward 29. On the east side of the city the Seventeenth Ward has 56, the Eighteenth Ward 13, the Nineteenth Ward 18, the Twenty-first Ward 20. In all the other Wards, with the exception of the Eleventh, which has 16, the whole number of slaughter-houses amounts to but 18, which are respectively located in the Twelfth, Thirteenth, Fourteenth, Fifteenth, and Sixteenth Wards. The weekly average of animals slaughtered in New York amounts to about 4,500 head of cattle, and 13,000 sheep, calves, and hogs. These slaughter-house establishments are generally conducted without the slightest regard to the public health, or to the comfort of the neighboring population. The blood and refuse are allowed to drain away in open sewers, or accumulate around the buildings; the animals are confined without food or water for days together, and the air is filled with the disgusting odors which arise from the decaying animal material, or from the works.

The removal of slaughter-houses beyond the city limits is urged, principally, on the ground of their being injurious to the public health. Although there is much evidence in proof of the correctness of this assertion, yet medical opinion is not unanimous upon this point. It is stated that the mortality of the neighborhood of the slaughter-houses of Paris fell 15 to 20 per cent. after their removal. Medical men have frequently testified to the origin and malignancy of fevers, and other zymotic disease, in the vicinity of these buildings. But then we have on record the remarkable report of Duchâtelet, on the establishment at Montfaucon, Paris, at which annually the "greater part of the bodies of 12,000 horses, and from 25,000 to 30,000 small animals are left to rot," the odor of which is sometimes perceptible at a distance of eight miles; and yet the employees are remarkably healthy, and attain to great age.

Whatever importance may be attached to this report, there can be no doubt that a slaughter-house in the midst

of a thickly populated part of the town is a great public and private nuisance, and should be abated. City Inspector BOOLE fully comprehends this fact, and proposes the only feasible remedy. He advises the removal of these establishments to the suburbs according to the French system, which is thus described:—

"There are five *abattoirs* in Paris, three in the northern and two in the southern limits of the city, which were constructed in accordance with a decree of Napoleon the First, in 1809, suppressing all the slaughter-houses then in operation. It is only necessary for our present purpose to give a description of one of these five establishments, and the largest of the five, which is called the *Abattoir de l'apincourt*. It consists of twenty-three distinct buildings, on a sloping ground, and within a walled inclosure 645 feet by 570 feet. In front of the abattoir is a small planted promenade. At the entrance are two pavilions, containing the offices of the administrator, and an *octroi*, or receiver's office. To the right and left of the central court, 438 feet by 291 feet, are four slaughter-houses, separated by a road crossing the inclosure. They are each 141 by 96 feet, and include, respectively, a flagged court, on each side of which are eight slaughter-stalls for the use of butchers, sixty in number, by whom the keys are kept. Each one of the slaughter-stalls receives light and ventilation from arcades in the front walls. Above are spacious attics for drying the skins and preparing the tallow. To preserve a cool temperature, a considerable elevation and projection have been given to the roofs. Behind the slaughter-houses are two ranges of sheds, containing sheep-pens, and at the extremities eight stables for about 400 oxen. Each of these buildings contains a loft for forage. At the end there is a watering place, and pens for cattle, besides two detached buildings, each traversed by a broad corridor which communicates with four melting-houses, below which are cellars containing coolers. Beyond these, and parallel with the outer wall, are two buildings, raised on cellars, in which the skins are kept; and near them in front of the entrance is a double reservoir for water 228 feet in length, built of solid masonry, and resting on arches which form stands for carts. There is also a '*triperie*' for washing and boiling tripe and calves' feet. The blood runs into a reservoir prepared for that purpose, and is removed therefrom by pumps, put into casks and sent to the different manufacturers who use it—such as chemists, sugar refiners, etc. The apparatus for slaughtering is uniform, and belongs to the establishment. The blood, offal, and manure are removed daily. Diseased cattle are sent to the pound outside of the city, where after a time they are slaughtered, and the meat used for sundry chemical and other purposes."

The chief opposition anticipated to the practical application of this action is from the butchers. Both in Paris and London they opposed it as an encroachment upon their inherent rights, and the imposition of unnecessary restrictions upon their business. MR. BOOLE enters into an estimate of the saving in expenses which the French system would bring to the butchers of this city. In the direct outlay of money this would be very considerable, amounting to but about one-third of the present expenses. To this must be added greater facilities in bringing forward animals to the place of slaughter, diminution of hands, increased facilities for marketing by the establishment of up-town markets, &c., &c. The special plan of the City Inspector, in putting his ideas into practical operation, is to erect four abattoirs on the Island, two on the east and two on the west side of the city, above Thirteenth street. The city already owns lots in the proper localities for these establishments.

In the opinion of the City Inspector the time has come when slaughter-houses must cease to exist in the compactly inhabited portion of our city. Laws for their better regulation must yield to their entire abolishment. Whether "there is no season more fitting than the present" to effect this great reform will remain to be seen; but of this there can be no doubt, that every good citizen should heartily endorse the action of MR. BOOLE, and exert all his influence to accomplish so desirable a change. If once inaugurated it will not only remove these local nuisances, but it will also relieve the streets of the herds of animals driven to market, and of that most disgusting of all street exhibitions, viz. drovers' carts, over-filled with sheep or calves. The opportunity which is now offered for sanitary reform, under the powerful influence of the present CITY INSPECTOR, should not be lost by indifference on the part of the people.

THE WEEK.

THERE has existed considerable doubt among physicians as to their liability under the Internal Revenue law to a tax on their incomes. The Commissioner has made several decisions. The following extracts embrace the principal points:

"It is asked whether an assessment for Income Tax is to be made upon collections during the year 1862, for professional services rendered during that year and previous years, and whether an estimate of unrealized, or contingent income due for services rendered in that year, ought to be included? I answer, that the assessment should be made upon all collections during the year 1862, without regard to whether the services were rendered during that or previous years. If any profits made during that year and uncollected, remain uncollected when they might have been readily realized, and with a view merely to avoid the assessment of the tax, they are to be considered as collected, and assessed accordingly; for no evasion of the liability of the tax-payer of his duty under the law, should be allowed to profit him. But merely contingent profits, uncollected, the sum not ascertained, remaining open for adjustment, are not liable to assessment.

"2d. As to 'expenses necessarily incurred in carrying on any trade, business, or profession,' physicians cannot be allowed the wear and tear of horses, carriages and harness, any more than they can of their own constitutions, or of their health, necessarily injured in the practice of their vocation; but any incidental expenses, such as the feeding of horses, hire of servants, and such like, are to be deducted from their income.

"The amount expended by a physician for the keeping of a horse used exclusively in the business of his profession, is a legitimate deduction from income."

—

"DRUNKENNESS in England has gradually risen into a most formidable social vice, as appears from the following statement in the *Lancet:*

By a Parliamentary paper lately issued, it appears that in the year ending Michaelmas, 1861, there were 54,123 persons, male and female, convicted of drunkenness in England and Wales; but in the year ending Michaelmas, 1862, the number convicted reached the high amount of 63,250, whilst not less than 100,000 were proceeded against before justices of the peace for being in a state of inebriety. Thus the disheartening increase of more than 9000 intoxicated persons was proved to have occurred last year! The proportion of drunkards convicted to those taken up did not alter, being in each year about 66 per cent. of those charged with this offence to our national character."

—

THE English Medical Act which compels every person practising medicine and surgery to be qualified and registered does not, it seems, prevent quacks from this country

obtaining a foothold in the profession. Many of these graduates from chartered medical colleges exhibit their diplomas, are registered, and commence practice. The profession of England should understand that our State Legislatures charter colleges of every complexion, and the graduates of these institutions are therefore legally qualified. The title of M.D. in this country has no significance whatever.

Reviews.

A Treatise on Hygiene, with Especial Reference to the Military Service. By William A. Hammond, M.D., Surgeon-General U. S. Army; Fellow of the College of Physicians of Philadelphia; Member of the Philadelphia Pathological Society; of the Academy of Natural Sciences; of the American Philosophical Society; Honorary Corresponding Member of the British Medical Association, etc., etc. Philadelphia: J. B. Lippincott & Co. 1863. 8vo. pp. 604.

When, in 1858, we read in the evidence given by distinguished medical officers before Sir Sidney Herbert's Commission of Inquiry, etc., that a suitable manual upon Military Hygiene did not exist; and that, as was stated by Sir John Hall, Prof. Parker, and the Director-General, Dr. Smith, a well arranged treatise was greatly needed in the Medical Department of the British Army, such confession of the want induced the hope that it would soon be supplied. And to the American soldier and surgeon such a tribute would have been no less welcome than to the British army. But the great war that so suddenly burst upon our unguarded republic called into the military service, as Dr. Hammond remarks in his Preface, "thousands of physicians to take the medical charge of the armies created —many of them well known for their professional eminence, and others, by far the greater number, young and inexperienced, though not lacking the will and ability to do their whole duty when that duty was pointed out to them;" but these physicians found no manual of Military Hygiene among the volumes generously furnished them by the Army Medical Bureau.

Called to the Surgeon-Generalship of the Army in the summer of 1862, in the midst of most exciting campaigns, and with an immense expansion of the service, Dr. Hammond might have repeated the excuse that was offered to the Commission of Inquiry, etc., by the British Director-General, when he stated that he had long had the intention of preparing a manual, but his official duties had not allowed him time for such work. That, under the overwhelming burdens of official duty in charge of the medical service for an army of a million of volunteers, the Surgeon-General should have planned and executed such a work as the treatise now before us, is the best of testimony to the practical estimate he places upon sanitary science and preventive medicine.

A treatise prepared so hastily, and under such pressure of vast official responsibilities, ought not to be—cannot be encyclopædic and complete, or in any sense an exhaustive treatise. It should be eminently practical, and adapted to the wants of the army medical officer. Manifestly this has been the design of the author; and, considered as a philosophical and practical treatise upon the principles and applications of sanitary science in the organization and medical care of armies, he has imparted to its chapters such scope of discussion and such accurate scientific statements as cannot fail to command the attention and awaken the interest, not only of medical officers and the profession generally, but of all educated men in the army.

The subjects discussed in the treatise are presented under three general heads:—

1. *The Examination of Recruits.*
2. *The Agents inherent in the Organism which affect the Hygienic Condition of Man.*
3. *Agents External to the Organism which act upon the Health of Man.*

These subjects are well presented in *twenty-nine* chapters, illustrated with twenty-four woodcuts.

The argument of the author is concisely stated in the Introduction. He says:—"In order that an army may be effective it must be healthy, and in order that it may be healthy the men composing it must be well formed, of good constitution, free from any disease which can impair their efficiency—and kept by physical, mental, and dietetic influences, in such a condition as will, if it do not entirely prevent disease, at least reduce the sickness to the lowest possible minimum. . . .

"To put a soldier into the field costs the government nearly four hundred dollars; should he die, or become permanently disabled in service, a pension is given. Looking at this matter, therefore, merely in a financial point of view, we perceive that it is a subject of serious importance that every means should be taken to preserve the lives and health of those who come forward to fight the battles of their country. . . .

"The greater number of diseases are, as we shall point out more at length hereafter, more or less preventible. When a preventible disease occurs some one is to blame, either the subject of it or those who are charged with the duty of providing for his well being."

This is the doctrine of hygienists, and from the text thus clearly stated by the author the discourse that follows is plain and practical. The first chapters are devoted to the examination of the various questions connected with the subject of qualifications and disqualifications, general and special.

(To be Continued.)

The Principles and Practice of Dental Surgery. By Chapin A. Harris, M.D., D.D.S. Eighth Edition: Enlarged and revised, with three hundred and twenty Illustrations. Philadelphia: Lindsay & Blakiston, 1863. Pp. 869.

The present edition of this work has been very greatly improved. The death of its lamented author compelled the publishers to engage the services of eminent dental writers, and several valuable chapters have been added. Prof. Austen has contributed a chapter on Vulcanite; Prof. Johnston, of Baltimore, Dr. Dwinelle of this city, and others, have added to different portions of the work. It may now be considered the most complete work on dental surgery.

Dr. Cyrus Ramsay, of the New York City Inspector's office, communicates to the *Reporter* the following facts on the comparative frequency of cancer in New York and London:

The annexed table shows the total deaths by this cause in New York, London, and England, in each year from 1851 to 1863:—

YEAR.....	1852	1853	1854	1855	1856	1857	1858	1859	1860	1861	1862
New York.....	91	77	107	147	154	187	189	198	180	173	169
London.....	936	1083	1021	1055	1074	1152	1142	1161	1191	1304	1321
England.....	5477	5663	5826	6016	5859	6201	6438	6676	6827	7402	7540

The annual average for ten years, in New York is 150. The annual average for ten years, in London, is 1,112. The proportion is 7½ in London to 1 in New York. When it is remembered that London contains about three times the population of New York, the excess of deaths by this disease in the former is more apparent.

Dr. John A. Lidell, Surgeon U.S.V., has been appointed Professor of Anatomy and Physiology in the National Medical College at Washington.

Prof. F. H. Hamilton has taken up his permanent residence in New York City.

Correspondence.

EXTREME ANÆMIA,

ACCOMPANIED BY A RARE FORM OF DISCOLORATION.

[To the Editor of the American Medical Times.]

Sir:—The patient came twice under my notice during the past summer, and the following is a brief description of her case.

She lives near Schodack on the Hudson river, is a native of this country, about twenty years of age, unmarried, of nervous temperament and delicate constitution. Her eyes are grey, her hair dark brown. Her face, which is one of considerable refinement, is extremely pale, even deathlike, her hands very thin and white, and her tongue and gums much lighter than the natural hue. Her whole appearance is that of a person who has sustained severe losses of blood, and this effect is heightened by contrast with two circles, which vary in color from jet black to a deep bluish black, and which surround the eyes and are parted by the bridge of the nose. They are about three-quarters of an inch in width, quite symmetrical in shape, and are constantly present, although varying at times to a trifling extent in depth of color. Unlike Stearrhœa they are not greasy or the result of an apparent exudation, but as a general rule are dry, and resemble stains upon or beneath normal integument. When rubbed the pigment can be partially removed, but the friction leaves the skin quite tender and the discoloration soon returns. A watery discharge sometimes takes place from the rings, and will blacken those portions of the integument upon which it runs.

The eyes suggest those of a ringdove, the rings being black, or the effect which is produced by the black leather spectacles which are occasionally worn by boys.

This discoloration was first noticed about two years since on the return of the girl's mother, after a few hours' absence. It was then of a greenish hue, but has gradually become darker. There is great hyperæsthesia of the surface, and the patient is very sensitive to cold. The pulse is very difficult to detect, being exceedingly small and frequent, and easily confounded with the twitchings of the flexor tendons at the wrist, which are in constant action. She has very little appetite, but likes clams in any form, and as a general rule, salt food in preference to fresh. Suffers considerably in consequence of a pain, perhaps connected with the ovaries, which extends from just above the lower ribs to the groin, and usually occupies the left side, although often felt upon the right. She does not complain of any pain in passing water.

Menstruation first occurred at eleven years of age, and the discharge continued to appear quite regularly, although somewhat scantily, until after a very severe attack of scarlet fever at the age of fourteen, which left her very much reduced. This was followed by menorrhagia until two years since, when the menses disappeared. For a year she has been subject to discharges of blood *per anum*, passing a large quantity almost daily, accompanied with spasms and violent pain. She has also suffered much from severe spasmodic paroxysms and from all the train of nervous symptoms to which anæmic and hysterical females are liable, but still maintains a good degree of resolution.

The remainder of the body is free from discolorations. Various methods of treatment have been resorted to at different times, but the patient still remains a constant sufferer.

I have not been able to find a similar case described in several books to which I have referred, and think it will interest the members of the profession.

Yours, etc.,

F. A. Burrall, M.D.

Physician to the Northern Dispensary.

Army Medical Intelligence.

GENERAL ORDERS, No. 308.

War Department,
Adjutant-General's Office,
Washington, September 12, 1863.

The Medical Inspector-General has, under direction of the Surgeon-General, the supervision of all that relates to the sanitary condition of the Army, whether in transports, quarters, or camps; the hygiene, police, discipline, and efficiency of field and general hospitals; and the assignment of duties to Medical Inspectors.

Medical Inspectors are charged with the duty of inspecting the sanitary condition of transports, quarters, and camps of field and general hospitals, and will report to the Medical Inspector-General all circumstances relating to the sanitary condition and wants of troops and of hospitals, and to the skill, efficiency, and conduct of the officers and attendants connected with the Medical Department. They are required to see that all regulations for protecting the health of troops, and for the careful treatment of and attendance upon the sick and wounded, are duly observed.

They will carefully examine into the quantity, quality, and condition of medical and hospital supplies, the correctness of all medical, sanitary, statistical, military, and property records and accounts pertaining to the Medical Department, and the punctuality with which reports and returns, required by Regulations, have been forwarded to the Surgeon-General.

They will ascertain the amount of disease and mortality among the troops, inquire into the causes, and the steps that may have been taken for its prevention or mitigation, indicating, verbally or in writing, to the medical officers such additional measures or precautions as may be requisite. When sanitary reforms, requiring the sanction and co-operation of military authority, are urgently demanded, they will report at once, in writing, to the officer commanding Corps, Department, or Division, the circumstances and necessities of the case, and the measures considered advisable for their relief, forwarding a duplicate of such reports to the Medical Inspector-General.

They will instruct and direct the medical officers in charge as to the proper measures to be adopted for the correction of errors and abuses, and, in all cases of conflict of views, authority, or instructions, with those of Medical Directors, will report the circumstances fully and promptly to the Medical Inspector-General for the Surgeon-General's orders.

Upon or near the beginning of each month, Medical Inspectors will make minute and thorough inspections of hospitals, barracks, camps, transports, &c., &c., within the districts to which they are assigned, in conformity with these instructions, and the forms for inspection reports furnished them.

Monthly inspection reports, in addition to remarks under the several heads, will also convey the fullest information in regard to the medical and surgical treatment adopted; the advantages or disadvantages of location, construction, general arrangement and administration of hospitals, camps, barracks; the necessity for improvement, alteration, or repair, with such recommendations as will most certainly conduce to the health and comfort of the troops, and the proper care and treatment of the sick and wounded. When alterations, improvements, or repairs, requiring the action of Heads of Bureaux, are considered essential, special reports, accompanied by plans and approximate estimates of quantities or cost, will be made.

Medical Inspectors will make themselves fully conversant with the regulations of the Subsistence Department in all that relates to issues to hospitals, whether general, field, division, or regimental, and will satisfy themselves, by rigid examination of accounts and ex; enditures, that the fund accruing from retained rations is judiciously applied, and not diverted from its proper purposes through the

ignorance or inattention of medical officers, giving such information and instruction on this subject as may be required. They will also give close attention to the supervision of cooking by the medical officer, whose duty it is, under the act of Congress of March 3, 1863, and General Orders, No. 547, of 1863, to "submit his suggestions for improving the cooking, in writing, to the commanding officer," and to accompany him in frequent inspections of the kitchens and messes.

They will exercise sound discrimination in reporting "an officer of the Medical Corps as disqualified, by age or otherwise, for promotion to a higher grade, or unfitted for the performance of his professional duties," and be prepared to submit evidence of its correctness to the Medical Board, by whom the charge will be investigated.

Medical Inspectors are also charged with the duty of designating, to the surgeon in charge of general hospitals and convalescent camps, all soldiers who are in their opinion fit subjects for discharge on surgeon's certificate of disability, or sufficiently recovered to be able for duty. In all such cases they will direct the surgeon to discharge from service, in accordance with existing orders and regulations, or return to duty those so designated.

Official communications to the Medical Inspector General will be directed to the Surgeon General, U.S.A., and plainly addressed on the left-hand lower corner of envelope. "For the Medical Inspector General," the name and title of the writer being *written* under the words "Official Business."

It is expected that all commanding officers will afford every facility to Medical Inspectors in the execution of their important duties, giving such orders as may be necessary to carry into effect their suggestions and recommendations; and it is enjoined upon all medical officers, and others connected with the Medical Department of the United States Army, to yield prompt compliance with the instructions they may receive from Medical Inspectors on duty in the Army, Department, or District in which they are serving, on all matters relating to the sanitary condition of the troops, and of the hygiene, police, discipline, and efficiency of hospitals.

By Order of the Secretary of War:

E. D. TOWNSEND,
Assistant Adjutant General.

ORDERS, CHANGES, &c.

Leave of absence for twenty days has been granted to Assistant-Surgeon L. Jewett, 14th Connecticut Vols.

Assistant-Surgeon James H. Hill, 30th Missouri Vols., having tendered his resignation, has been honorably discharged the service of the United States on account of physical disability, he having been absent sick since February 11, 1863, as reported by the rolls of his regiment.

Leave of absence has been granted to Acting Assistant-Surgeon W. J. C. Duhamel, U.S.A., for ten days.

The resignation of Surgeon Charles Mayo, U.S.V., has been accepted by the President, to take effect September 8, 1863.

Surgeon L. C. Rice, U.S.V., has relieved Assistant-Surgeon H. R. Tilton, U.S.A., in charge of Floating Hospital "Nashville," Vicksburg, Miss.

Surgeon G. Grant, U.S.V., has been relieved from duty at Evansville, Ind., and assigned to duty as Superintendent of Hospitals, at Madison, Ind.

Surgeons G. Taylor, U.S.A., and Alexander B. Mott, U.S.V., have been assigned to duty as members of the Board in session at New York, for the examination of Surgeons and Assistant-Surgeons of colored troops.

Surgeon J. J. Craven, U.S.V., is on duty at Morris Island, S. C., as Chief Medical Officer of troops under command of General T. Seymour.

Surgeon M. Clymer, U.S.V., has been assigned to duty as Chief Medical Officer, at Beaufort, S. C.

Surgeon R. B. Bontecou, U.S.V., is sick in quarters at Hilton Head, S. C.

Surgeon J. E. McDonald is temporarily on duty as Medical Director, 9th Army Corps, during the absence of Surgeon W. C. Otterson, U.S.V., who is on leave at his home for the benefit of his health.

Surgeons J. L. Teed, Francis Salter, G. W. Hogeboom, and W. Threlkeld, U.S.V., and Assistant-Surgeons C. S. Frink and William Carroll, U.S.V., have been appointed to the Cumberland Hospital, Nashville, Tenn.

Surgeon James T. Ghiselin, U.S.A., has been ordered to report for duty to Major-General Meade, commanding Army of the Potomac.

Surgeon E. Shippen, U.S.V., has been ordered to report to Surgeon W. S. King, U.S.A., Medical Director at Philadelphia, Penn., to relieve Surgeon P. B. Goddard, U.S.V., in charge of the South street General Hospital in that city.

Surgeon A. M. Clark, U.S.V., is under medical treatment at Washington, D. C. Dr. C. is suffering from the effects of sunstroke, received some time ago.

The Mansfield General Hospital at Morehead city, N. C., is completed and is receiving patients. Surgeon J. B. Bellangee, U.S.V., is in charge.

The General Hospital in the Central Park, New York, will not be discontinued.

The Board of Officers convened by Special Orders 356 of August 11, 1863, from the Adjutant-General's Office, "to examine all convalescents for admission to the Invalid Corps, that may be found at the various hospitals in and around Philadelphia," has been dissolved.

The Medical Department has received intelligence of the death of Surgeon B. Darrach, U.S.V., at Vicksburg, Miss., in July last.

Leave of absence for fifteen days has been granted Act. Assistant-Surgeon F. G. H. Bradford, U.S.A., with permission to visit Hilton Head, S.C.

Assistant-Surgeon Abel C. Benedict, U.S.V., has been promoted Surgeon to date September 16, 1863.

Sherman Morse, late Assistant-Surgeon, 2d New York Cavalry, whose appointment was revoked by Special Orders, No. 275, Adjutant-General's Office, has been restored to his regiment, with pay from date of rejoining it, provided the vacancy has not been filled, and that the regiment is not deprived of one Assistant-Surgeon under the requirements of General Orders No. 182. Evidence of the vacancy to be obtained from the Governor.

Leave of absence for five days has been granted to Assistant-Surgeon S. B. Ward, U.S.A.

Surgeon A. M. Clark, U.S.V., has been relieved from duty with the Army of the Potomac, and ordered to repair to Washington, and report for duty to Colonel Hoffman, Commissary General of Prisoners.

So much of Special Orders No. 404, September 9, 1863, as discharged Assistant-Surgeon James H. Hill, 30th Missouri Volunteers, is hereby revoked, he having been previously discharged by Special Orders 395, September 8, 1863, from the Adjutant-General's Office.

Surgeon William Moss, U.S.V., has tendered his resignation.

The resignation of Hospital Chaplain Charles Seymour has been accepted by the President.

So much of Special Orders No. 408, September 11, 1863, as directed Assistant-Surgeon William S. Ely, U.S.V., to report to Major-General Foster, Commanding Department of Virginia and North Carolina, has been revoked, and he will report for duty to the Surgeon in charge Division No. 1, Annapolis General Hospital.

Surgeon William H. Church, U.S.V., Medical Director of the Dept. of the Ohio, has been granted thirty days' leave, with permission to tender his resignation at the expiration of his leave.

Surgeon Thomas F. Perley, U.S.V., has been assigned to duty at Portland, Maine, and will render medical services to all officers and soldiers of Volunteers who may be in that city.

Assistant-Surgeon Alexander Collar, 24th Michigan Volunteers, has been honorably discharged on account of physical disability and for absence without leave as reported on the rolls of his regiment.

Medical News.

Cholera at Bombay.—A sharp visitation of cholera in Bombay has carried off several Europeans, but the scourge has now disappeared.—*Lancet.*

Obscene Circulars.—Rascality seems to have manifested curious ingenuity in furtherance of the schemes of a so-termed American medical practitioner, who, calling himself a doctor, lives where those whom he addresses most do congregate. A yellow bill, setting forth in most unmistakable terms that which he proposes to treat, has attached to it a small slip of adhesive paper, which enables it to be fastened to the backs of private carriages standing in the streets. This bill, printed in true sensation style, is headed "No cure, no pay," and appropriately, on the part of the alleged American physician, announces his overtures to the public.—*Lancet.*

The Ventilation of Ships.—A plan of ventilation, invented and patented by Dr. Edmonds, Staff-Surgeon of the *Victory*, is to be tested in the turret-ship *Royal Sovereign*, at present in course of construction at Portsmouth. Dr. Edmonds's proposed system is self-acting, and it professes—

Not only to furnish an ample supply of pure fresh air to the crew, but also to effect the very important object of preserving the ship's timbers from decay or dry rot, by creating a constant circulation of air throughout the framework of the ship. This is effected by converting the timber spaces from the keel upward, between the "ribs," so to speak, of the ship, into draught channels leading into a tunnel shaft fore and aft on each side of the ship's berthing deck, which communicates by cross shaftings with the funnel, the draught of the funnel furnishing the motive power for the suction of a continuous current of air upwards through the ship's timbers, and carrying off the foul air and gases from the ship's hold and bilges without tainting the air the crew breathe on the berth deck.—*Med. Times and Gaz.*

MARRIAGE.

WASHBURN—RUSS.—On Tuesday, Sept. 1, at the residence of the bride's mother, by Rev. Charles C. Wallace, Dr. S. D. Washburn, House Physician to Seamen's Retreat, Staten Island, and Elizabeth Crowell Russ, of Perth Amboy, N. J.

DEATHS.

GUNN.—At Hospital of Second Division, Third Army Corps, near Potomac Creek, Va., June 2d, of enteric fever, Assistant Surgeon Neil K. Gunn, First Massachusetts Volunteer Infantry, First Brigade, Second Division, Third Army Corps.

Dr. GUNN was a native of Nova Scotia, a graduate of Harvard at its last commencement, and had been on duty with his regiment but about six weeks. He was buried with imposing military ceremonies, his funeral being attended by the Medical Staff of the Division and many other officers.

HOLMES.—In camp near Germantown, Fauquier County, Va., on the 23d of June last, of diphtheria, after an illness of only six days, Dr. Freeland S. Holmes, Surgeon of the Sixth Regiment Maine Volunteers, of Foxcroft, Me.

JACKSON.—On the 4th inst., at Providence Hospital, in care of Sisters of Charity, Washington City, D. C., of typhoid fever, contracted on the battlefield at Gettysburg, Dr. E. Owen Jackson, Assistant Surgeon Second Regiment P. R. V. C., aged 26 years, son of E. O. Jackson, of this city.

BROWN.—In Baton Rouge, La., Dr. Samuel H. Brown, of the One Hundred and Seventy-fourth Regiment, New York State Volunteers, formerly of New York City, in the 39th year of his age.

WAINWRIGHT.—In New Orleans, on Wednesday, Aug. 5, of typhoid fever, acquired in camp before Vicksburgh, Dr. D. Wadsworth Wainwright, Surgeon U. S. V., in the 31st year of his age.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 14th day of September to the 21st day of September, 1863.

Deaths.—Men, 99; women, 96; boys, 122; girls, 150; total, 467. Adults, 195; children, 272; males, 221; females, 246; colored, 5. Infants under two years of age, 207. Children born of native parents, 12; foreign, 242.

Among the causes of death we notice:—Apoplexy, 2; infantile convulsions, 25; croup, 12; diphtherite, 10; scarlet fever, 7; typhus and typhoid fevers, 15; consumption, 64; small-pox, 2; measles, 0; dropsy in head, 12; infantile marasmus, 47; cholera-morbus, 6; cholera infantum, 5; inflammation of brain, 8; of bowels, 12; of lungs, 22; bronchitis, 1; effects of heat and sun-stroke, 0; erysipelas, 0; diarrhœa and dysentery, 29. 243 deaths occurred from acute diseases, and 34 from violent causes. 322 were native, and 145 foreign; of whom 99 came from Ireland; 54 died in the City Charities; of whom 11 were in Bellevue Hospital, and 13 in the Immigrant Institution.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

Sept. 1863.	Minimum Temperature.	SIX A.M. Temperature.	Evaporation Below.	Barometer.	Wind.	TWO P.M. Temperature.	Evap. Below.	Barometer.	Wind.	TEN P.M. Temperature.	Evap. Below.	Barometer.	Wind.
	°	°				°				°			
13th.	54	60	4	29.93	N. by W.	65	8	29.91	N.	58	4	30.00	N.E.
14th.	54	56	5	30.14	N.	68	7	30.14	N.	60	6	30.15	S.
15th.	56	57	4	30.20	S.	71	6	30.20	S.	67	5	30.19	S.
16th.	61	61	4	30.17	Fog.	76	8	30.16	S. by W.	70	5	30.12	S.
17th.	66	67	4	30.05	S.	75	7	30.02	S.	72	4	29.90	S.
18th.	58	70	5	29.74	S.E.	75	4	29 47	E.	68	5	29.44	N.E.
19th.	45	56	6	29.77	N.E.	48	7	29.80	N.E.	46	6	29.80	N.E.

REMARKS.—18th and 14th, Cloudy; wind mostly fresh. 15th and 16th, Clear and sultry. 17th, Cloudy and sultry. 18th, Cloudy; rain P.M. 19th, Cloudy; rain at intervals; fresh wind. Rain for the week, one inch.

TERMS OF THE AMERICAN MEDICAL TIMES.

City and Canadian Subscribers, $3.50 per annum, payable in advance.
Mail Subscribers, $3 per annum, payable in advance.
Remittances must accompany an order for the Journal.
The Publishers will not hold themselves responsible for the loss of moneys inclosed in unregistered letters.
There are two volumes a year, commencing on the 1st of January and July; but subscriptions may begin at any date.
Those who desire to have the series complete can be supplied with the back numbers at the original subscription price.
The last volume, nicely bound in cloth, may be had at the office, for $2 00, and free by mail for $2.32; cloth cases for binding may be had at the office for 25 cents, and free by mail for 34 cents.

*** THE MEDICAL TIMES is published every Saturday morning, and is transmitted direct by mail throughout every section of the country. As a medium for immediate communication with the medical profession of the United States, it offers unsurpassed facilities to those desiring to advertise Medical Colleges and Schools, late Works, Surgical Appliances, Instruments of every kind, Drugs and Medicines, etc., etc. The following terms of transient advertisements may be modified by special contract for permanent insertion:

¼ column, or less,	each insertion	$1 00
½ "	"	1 80
¾ "	"	3 60
1 "	"	7 20

A deduction of 10 per cent is made for 6 insertions.
" 25 " " " 13 "
" 30 " " " 26 "
" 35 " " " 52 "

Communications should be addressed "Office American Medical Times, 440 Broadway, N. Y." BAILLIERE BROTHERS,
Publishers and Proprietors,